STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of Complaint IN00095676. Complaint IN00095676: Substantiated, Federal/State deficiencies related to the allegations are cited at F312, F282 and F314. Survey dates: 9/26 and 9/27/11 Facility number: 000521 Provider number: 155582 Aim number: 100266980 Survey Team: Ellen Ruppel, RN, TC Ann Armey, RN Carol Miller, RN (9/27/11) Census bed type: SNF: 17 SNF/NF: 102 Total: 119 Census payor type: Medicare: 9 Medicaid: 88 Other: 22 Total: 119 Sample: 7 These deficiencies also reflect state	F0000	Please accept this POC as our credible allegation of compliance. The facility respectfully requests a face to face IDR for F-tag 314.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	findings cited in accordance with 410 IAC 16.2. Quality review completed 9/29/11 Cathy Emswiller RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interviews and record review, the facility failed to follow the physician's orders for administering a vitamin/iron/mineral supplement for 1 or 4 residents in a sample of 7. Resident #B Findings include: The clinical record of Resident #B was reviewed, on 9/27/11 at 10:05 a.m., and indicated the resident had been admitted to the facility on 8/19/11. His diagnoses included, but were not limited to: cerebrovascular accident (stroke), hypertension and hemiplegia.	F0282	It is the policy of Miller's Merry Manor, Wakarusa that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care.Resident # B: The order for Multivitamin with iron was received on 8/29/2011. The pharmacy called the facility and asked that the order be clarified to Multivitamin with minerals and iron. A clarification order was written, but the pharmacy never received the clarification. On 9/16/2011 the facility received the multivitamin with iron/minerals and have been administering daily as ordered. All future physician orders for resident will be implemented and followed per plan of care.All residents are at	10/27/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the physician's orders, indicated the physician had ordered a complete blood count, on 8/28/11. The report indicated the residents white count was high at 11.95 (normal 4.0-11.0), the red blood cell count was low at 3.89 (normal 3.9-5.9), the hemoglobin was low at 10.8 (normal 13.0-17.3) and the hematocrit was low at 34.5 (normal 39.0-53.0). The physician had ordered multivitamins with minerals and iron, on 8/29/11. Review of the Medication Administration Record (MAR) for the months of August and September, 2011, indicated the medication had been circled or not given 13 of 17 days from 8/29 to 9/15/11. The information on the back of the MAR indicated the vitamin was not available. During an interview with the Director of Nursing (DoN) on 9/27/11 at 11:00 a.m., she indicated she had not been made aware the medication was not being given and had checked with the pharmacy. The DoN indicated the pharmacy told her they had not received the order, and the vitamins had not been sent until the nurse called on 9/15/11. The DoN checked the (emergency drug system) and found the vitamin had been available in the facility, but had not been taken out for Resident		risk to be affected by the deficient practice. The facility nurse managers completed an audit of all MAR's and TAR's on 9/27/2011 to ensure that each resident is getting meds and treatments as ordered by physician. An all staff in-service with all staff who administer medications/treatments will be held on or before 10/26/2011 and the facility policy for "New Orders" (attachment A),"Monthly Consolidated Orders" (Attachment B), "Physicians Order Transcription Procedure" (Attachment C) will be reviewed. The charge nurses will be instructed in the event a medication or treatment is not available the facility pyxis machine will be accessed and a phone call will be made to the pharmacy. The charge nurse will also be responsible to indicate on the 24hour report tool that the pyxis machine had to be accessed to obtain needed med or treatment. If the medication or treatment is not available in the facility pyxis machine the pharmacy will be contacted and instructed to send from the back-up pharmacy. The charge nurse will also be responsible to contact the DON or other nursing designee to notify that the item is not available and that the back up pharmacy is suppose to deliver. The charge nurses will be instructed to administer upon receipt of needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#B. Review of a second hemoglobin and hematocrit, ordered by the physician to be done 9/12/11, after the vitamin/mineral/iron supplement had been administered for a two week period, indicated the hemoglobin remained at 10.8 and the hematocrit was slightly better at 34.8. This federal tag relates to Complaint IN00095676. 3.1-35(g)(2)		medication/treatment unless otherwise contraindicated. The DON or other nursing designee will follow up to ensure that medication/treatment is made available and administered as ordered by the physician. The 24hour report tool will serve as a communication device that is reviewed routinely by the nurse managers and any notation that the pyxis machine has been accessed will be reviewed by nurse manager to ensure medication/treatment was delivered as ordered.The unit managers or other designee will be responsible to complete the QA tool titled "Physician Order Review" (Attachment J) on all new orders daily for the next 14days, then on 10 new physician orders for each seperate unit weekly for 30days, then 10 new orders weekly for the next 6 months to ensure medications and treatments are administered per order. The QA tool "Physician Order Review" will also include MAR/TAR review 3x weekly to ensure that existing medication and treatment orders are available and delivered as ordered. Any identified issues will be logged on a QA tracking log and reviewed during the monthly facility QA meeting to monitor for ongoing compliance.	
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interviews and record review, the facility failed to provide care and service to promote the toileting for residents. This deficiency affected 3 of 7 residents in a sample of 7. (Residents #G, #H and #C) Findings include: 1. On 9/26/11 at 3:05 p.m., LPN #1 indicated Resident #G was incontinent at times and required assistance to use the bathroom. On 9/26/11, between 3:10 p.m. and 7:05 p.m., Resident #G was observed and was not taken to the bathroom or toileted. Observations of Resident #G included but were not limited to, the following: At 3:10 p.m., the resident was sleeping in a recliner on the unit and was holding a bell in her hand to summon help. At 4:00 p.m., the nurse spoke to the resident but she continued to sleep. At 4:30 p.m., the resident continued to sleep in the recliner holding the bell. At 5:00 p.m., the resident continued to sleep in the recliner. At 5:30 p.m., the resident was transferred to a wheelchair and taken directly to the dining room. At 6:00 p.m., the resident was being assisted to eat in the main dining room. At 6:10 p.m., the resident was returned to	F0312	It is the policy of Miller's Merry Manor, Wakarusa that ADL care is provided to a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.Resident #G,#H,#C: The HCP team has reviewed and updated plans of care. Nursing assignment sheets updated to reflect HCP specific interventions for toileting needs. The facility will provide ADL care as identified in each individual residents plan of care. All residents are at risk to be affected by the deficient practice. The nurse managers or other designee will review the ADL care needs of dependent residents and update/review current plan of care. The C.N.A. assignment sheets serve as the communication device for direct care staff to know the specific toileting needs of individualized residents. An all staff nursing meeting will be held on or before 10/26/2011 to discuss the facility policy and procedures for "Skin Management Procedures" (Attachment D), "Bowel and Bladder Assessment and Elimination" (Attachment E), and resident care topics from the "Basic Nurse Aide Program" for caring for dependent residents will be reviewed. The charge nurses will be responsible to make routine walking rounds of the units they are assigned to	10/27/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the unit in her wheelchair. At 6:40 p.m., the resident continued to sit in her wheelchair on the unit but had pulled off her wig. At 7:05 p.m., the resident continued to sit in the wheelchair on the unit and no attempt was made to toilet or take Resident #G to the bathroom to be checked or changed. The clinical record of Resident #G was reviewed on 9/27/11 at 9:30 a.m., and indicated the resident was admitted to the facility on 6/17/11, with diagnoses which included but were not limited to, paralysis agitans, and hypertonicity of bladder. The Quarterly MDS (Minimum Data Set) Assessment, dated 9/23/11, indicated the resident's had moderately impaired decision making, required extensive assistance for transfer/toileting and was frequently incontinent of bladder. The care plan, initiated 6/17/11, indicated Resident #G was incontinent of bowel and bladder with the potential for skin breakdown. The care plan indicated "Assist to toilet and/or check and change every 2 hr (hours)." On 9/27/11 at 1:30 p.m., Resident #G was observed being toileted by CNAs #3 and #4. The resident's buttock was red and a		monitor that toileting care is delivered as outlined in each individual residents plan of care. The unit managers or other designee will be responsible to update C.N.A. assignment sheets with any changes in plan of care promptly to ensure direct care staff have HCP information to deliver needed care to dependent residents. The nurse management team will also make walking rounds of the facility on all three shifts randomly for the next 10days to ensure the toileting of dependent residents is implemented per plan of care.The facility nurse managers or other designees will complete the QA tool "Care Plan Review" (Attachment F) and "Bowel and Bladder Incontinence Review" (Attachment G) weekly for the next 6 weeks on at least 20 residents each week, then monthly thereafter to ensure ongoing compliance. Any identified trends or issues will be immediately corrected and logged on facility tracking log. Tracking log will be reviewed during the monthly QA meeting to ensure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	perineal barrier ointment was applied. 2. On 9/26/11 at 3:05 p.m., LPN #1 indicated Resident #H was incontinent at times and required assistance to use the bathroom. On 9/26/11, between 3:20 p.m. and 7:05 p.m., Resident #H was observed and was not taken to the bathroom or toileted. Observations of Resident #H included but were not limited to, the following: At 3:20 p.m., the resident was sleeping in a recliner on the unit covered by a blanket. Her shoes were on the floor. At 4:00 p.m., the resident continued to sleep in the recliner. At 4:20 p.m., the resident was awaken to take medicine. At 5:00 p.m., the resident continued to sleep in the recliner. At 5:20 p.m., the resident's shoes were put on her feet and she was transferred to a wheelchair and taken directly to the dining room. At 5:45 p.m., she was eating fruit in the main dining room. At 6:40 p.m., the resident was returned to the unit in her wheelchair. At 6:45 p.m., the resident was offered crackers and a shake. The resident ate the crackers. At 7:00 p.m., the resident was transferred from the wheelchair to the recliner.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #H was not toileted or taken to the bathroom before or after the evening meal. On 9/26/11 at 7:05 p.m., CNA #2 was queried about not toileting the resident. The CNA indicated the resident had not asked to use the bathroom and as a result he had not taken her to be toileted. The clinical record of Resident #H was reviewed on 9/27/11 at 10:45 a.m. and indicated the resident was admitted to the facility on 4/27/10 with diagnoses which included but were not limited to, dementia, orthostatic hypotension and diabetes mellitus. The Quarterly MDS (Minimum Data Set) Assessment, dated 8/4/11, indicated the resident had severe cognitive impairment, required extensive assistance for transfer/toileting and had was occasionally incontinent of bladder. Resident #H's care plan, initiated 8/11/10, indicated "Assist to toilet upon arising, before and after meals, bedtime and upon request and every 2 hours at night." 3. The closed clinical record of Resident #C was reviewed, on 9/26/11 at 3:30 p.m., and indicated she had been admitted to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility on 7/28/11. Her diagnoses included, but were not limited to: dementia, cerebrovascular accident (stroke), diabetes and Whipple procedure for cholangiocarcinoma. The MDS assessments, of 8/15/11 and 8/23/11, indicated she was totally dependent for activities of daily living. Admission orders included Jevity tube feedings via gastrostomy tube and care of a Foley urinary catheter. Care plan interventions, dated as initiated 8/18/11, indicated "Assist to bedside commode on request." The resident was receiving docusate stool softener 150 mg daily, and had been observed by nurses, on 8/4/11 at 23:01 (11:01 p.m.) to have hemorrhoids, with scant bleeding. Nurses notes, dated 8/7/11 at 07:24 a.m., indicated "Res (resident's) son requested res to be taken to bathroom at 945pm (sic), CNA's took res to bathroom where res had small BM (bowel movement), at 11pm res son requested for res to be taken to bathroom again, CNA explained to son that res could be taken to bathroom every two hours, res son stated 'that wont (sic) do, I want to talk to the nurse.' This nurse went to room and tried explaining to son that res could be taken to bathroom every			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	two hours, son replied 'if you are giving her something to make her go and you dont (sic) take her that is abuse.' This nurse explained that res was not given something to 'make her go', res was given a stool softener to help soften her stools so she does not get impacted. Res son stated that if she was not taken to the bathroom he would seek legal help. At this time it was 1130pm and res was taken to bathroom and had no results." This federal tag relates to complaint IN00095676. 3.1-38(a)(2)(c)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interviews and record review, the facility failed to implement an intervention of vitamin/iron/mineral supplement to promote healing of an open area that was 5.5 cm by 3.5 cm with eschar present, for	F0314	It is the policy of Miller's Merry Manor, Wakarusa to provide treatment and services that prevent the development of pressure sores unless the individual's clinical condition demonstrates that they were	10/27/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1 or 4 residents in a sample of 7, who was at risk for skin breakdown. Resident #B Findings include: The clinical record of Resident #B was reviewed, on 9/27/11 at 10:05 a.m., and indicated the resident had been admitted to the facility on 8/19/11. His diagnoses included, but were not limited to: cerebrovascular accident, hypertension and hemiplegia. The admission assessment, dated 8/19/11 and a subsequent assessment on 9/18/11 indicated the resident had no skin breakdown. The initial observation date for the Minimum Data Set (MDS) assessment, dated 8/30/11, indicated the resident was at risk for skin breakdown due to being totally dependent for transfers, in need of extensive assistance for bed mobility, non-ambulatory, needing extensive assistance for eating and being in need of extensive assistance for toileting and personal hygiene. The MDS also indicated he was impaired on one side both with upper and lower extremities. The assessment indicated he was continent of bowel and had a Foley catheter for urine. The 8/30/11, MDS indicated no skin breakdown. The initial care plan, dated 8/19/11,		unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.Resident #B: An order for Multivitamin with minerals/iron was received on 8/29/2011. The resident did not have a pressure area at the time the multivitamin with minerals/iron was ordered. The multivitamin with minerals/iron has been given daily as ordered since 9/16/2011. A skin risk assessment was completed at admission per facility policy. Head to toe skin assessments completed per licensed nurse weekly. Resident had pressure relieving device in place on bed and in wheelchair at admission. Resident had a specific HCP for the prevention of pressure ulcer development and all interventions were followed per plan of care and the intervention of multivitamin/minerals/iron was not included in plan for the prevention of pressure ulcers. All residents are at risk to be affected by the deficient practice. The facility nurse managers completed an audit of all MAR's and TAR's on 9/27/2011 to ensure that each resident is getting meds and treatments as ordered by physician. An all staff in-service with all staff who administer medications/treatments will be held on or before 10/26/2011 and the facility policy for "New	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the interventions for prevention of skin breakdown were: "*Skin assessment at least weekly by nurse *Provide pressure reducing device to bed *Provide pressure reducing device to chair *Encourage meal/fluid intake and record *Monitor labs as available *Serve diet as ordered *Provide pericare as needed *Monitor skin daily during care *notify physician and family of any change in skin integrity *Remind or assist to turn at least every 2 hr *Skin assessment upon admission and then every shift for the first 3 days *Assist to toilet &/or check and change at least every 2 hr *Provide a 4 oz vitamin C enriched juice daily *Offer two entree selections every meal. In addition, use the always available alternate list as needed *Provide a well balanced diet that meets 100% of the RDI's & an minimum of 2000 calories, 80 GM of protein, 1500 ml of fluid *Provide a nourishing HS (hour of sleep) snack *Assess food likes and dislikes *See nutritional plan of care"		Orders" (attachment A),"Monthly Consolidated Orders" (Attachment B), "Physicians Order Transcription Procedure" (Attachment C) will be reviewed. The charge nurses will be instructed in the event a medication or treatment is not available the facility pyxis machine will be accessed and a phone call will be made to the pharmacy. The charge nurse will also be responsible to indicate on the 24hour report tool that the pyxis machine had to be accessed to obtain needed med or treatment. If the medication or treatment is not available in the facility pyxis machine the pharmacy will be contacted and instructed to send from the back-up pharmacy. The charge nurse will also be responsible to contact the DON or other nursing designee to notify that the item is not available and that the back up pharmacy is suppose to deliver. The charge nurses will be instructed to administer upon receipt of needed medication/treatment unless otherwise contraindicated. The DON or other nursing designee will follow up to ensure that medication/treatment is made available and administered as ordered by the physician. The 24hour report tool will serve as a communication device that is reviewed routinely by the nurse managers and any notation that the pyxis machine has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The dietary note, of 8/22/11, indicated the resident was receiving double portions of protein for low labs. The nutritional care plan indicated the resident had low hemoglobin and hematocrit. The plan indicated he was getting a bedtime snack and vitamin C fortified juice. Review of the weight record indicated the resident's weight was stable from 196.8 lbs on 8/20/11, to 199.6 lbs on 8/30/11, and 200.8 lbs on 9/20/11. Nurses notes, dated 9/20/11 at 12:12 p.m., indicated "Noted area on right gluteal fold that is covered with eschar--see wound notes. Dr (physician's name) notified with new orders for dressing, supplement, and referral to wound md (medical doctor). Low air loss mattress applied and ROHO cushion placed in wheelchair. Message left for (daughter) to call for updates." The wound assessment indicated the area was 5.5 cm by 3.5 cm with eschar present. The assessment indicated the resident wanted to sit in his wheelchair all day. Review of the physician's orders, indicated the physician had ordered a complete blood count, on 8/28/11. The report indicated the residents white count was high at 11.95 (normal 4.0-11.0), the red blood cell count was low at 3.89		accessed will be reviewed by nurse manager to ensure medication/treatment was delivered as ordered.The unit managers or other designee will be responsible to complete the QA tool titled "Physician Order Review" (Attachment J) on all new orders daily for the next 14days, then on 10 new physician orders for each seperate unit weekly for 30days, then 10 new orders weekly for the next 6 months to ensure medications and treatments are administered per order. The QA tool "Physician Order Review" will also include MAR/TAR review 3x weekly to ensure that existing medication and treatment orders are available and delivered as ordered. Any identified issues will be logged on a QA tracking log and reviewed during the monthly facility QA meeting to monitor for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(normal 3.9-5.9), the hemoglobin was low at 10.8 (normal 13.0-17.3) and the hematocrit was low at 34.5 (normal 39.0-53.0). The physician had ordered multivitamins with minerals and iron, on 8/29/11. Review of the Medication Administration Record (MAR) for the months of August and September, 2011, indicated the medication had been circled or not given 13 of 17 days from 8/29 to 9/15/11. The information on the back of the MAR indicated the vitamin was not available. During an interview with the Director of Nursing (DoN) on 9/27/11 at 11:00 a.m., she indicated she had not been made aware the medication was not being given and had checked with the pharmacy. The DoN indicated the pharmacy told her they had not received the order, and the vitamins had been sent until the nurse called on 9/15/11. The DoN checked the (emergency drug system) and found the vitamin had been available in the facility, but had not been taken out for Resident #B. Review of a second hemoglobin and hematocrit, ordered by the physician to be done 9/12/11, after the vitamin/mineral/iron supplement had been administered for a two week period,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the hemoglobin remained at 10.8 and the hematocrit was slightly better at 34.8. The resident had also been diagnosed with a urinary tract infection and started on the antibiotic Cipro 500 mg, twice daily, of 10 days on 9/19/11. The care plan related to the skin breakdown, dated 9/20/11, indicated "supplemental vitamins as ordered." Review of albumin and prealbumin levels, dated 9/22/11, indicated the resident's albumin was low at 2.9 (normal 3.5-5.2) and the prealbumin was low at 10.0 (normal 20.0-40.0). Prostat AWC (nutritional supplement) was added twice daily 9/20/11. The area on Resident B's gluteal area was observed during a dressing change, on 9/27/11 at 9:55 a.m., with LPN #9 measuring the area. The area was found to be 5.6 cm by 3.5 cm with a depth of .3 cm. This was slightly larger than the original area identified on 9/20/11. During interview at that time, LPN #9 indicated the physician had debrided the area and was coming on 9/28/11 to do another debridement. Santyl and a dressing was applied by RN #10.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This federal tag relates to Complaint IN00095676. 3.1-40(a)(1) 3.1-40(a)(2)			